Authorization for Dental Services

Patient Information

Patient Name:

Date of Birth:

Address:

Dental Provider Information

Provider Name:

Clinic Name:

Services Authorized

Describe Dental Services to be Performed:

Date of Service:

Authorization

I hereby authorize the above dental provider to perform the services listed above.
I have read and understand the nature and purpose of the dental treatments to be given, and I give my consent.

Patient's Signature:

Date: